TRICARE Fundamentals Course

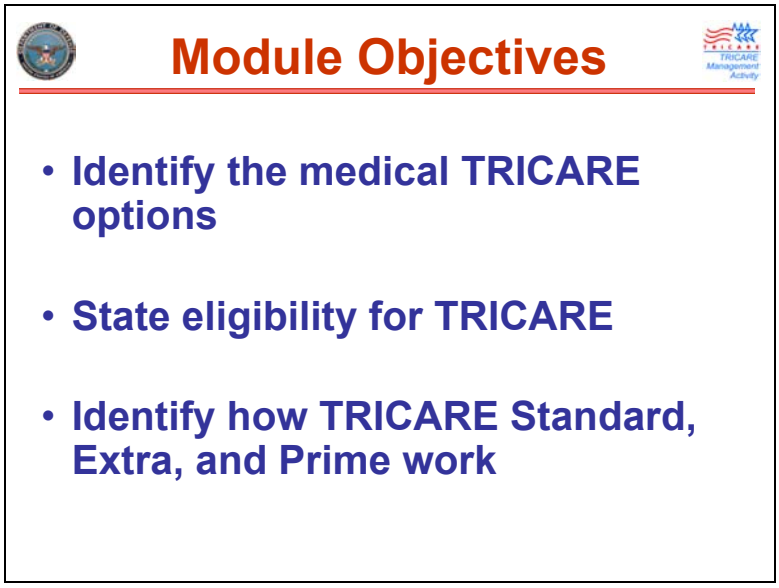
Module 5

Medical Benefits

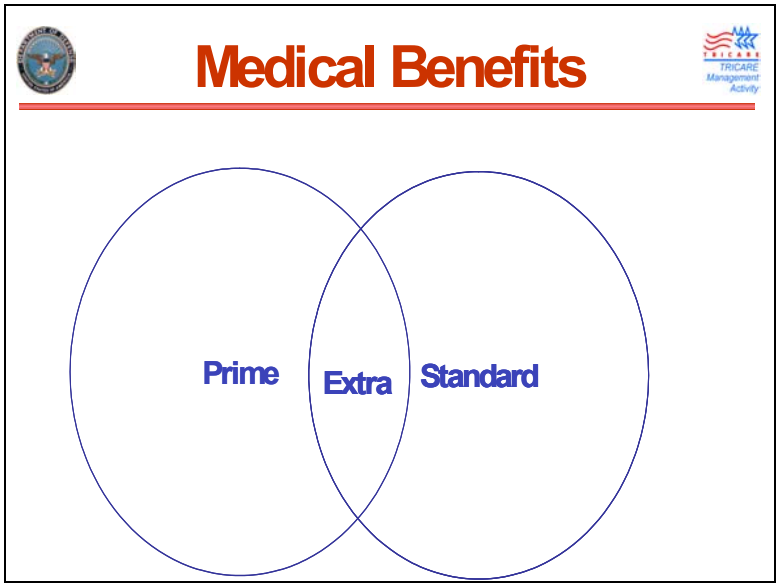
Participant Guide

References
10 U.S.C.
32 CFR §§ 199.14, 18, 20
National Defense Authorization Act (NDAA)
Defense Appropriations Act
TRICARE Policy Manual 6010.47-M

Module Objectives



Medical Benefits



Eligibility for TRICARE:

- Active duty service members and their families
- Retirees and their families
- Survivors of all uniformed services who are not eligible for Medicare

Kinds of Providers

The beneficiary is responsible for ensuring the provider is a TRICARE-authorized provider. Recommend beneficiaries contact the office manager of the provider and the regional TRICARE Service Center (TSC).

Authorized Provider

An authorized provider is a doctor or other individual provider of care, hospital, or supplier licensed by the state, accredited by a national organization, or meets other standards of the medical community, and is certified by TRICARE to provide benefits under TRICARE. Regional TRICARE contractors must verify (certify) a provider's authorized status before they can pay for services received from that provider. If the provider is not authorized, TRICARE cannot help pay the bill.

Network Provider

A network provider is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor.

Non-network Provider

A non-network provider is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries.

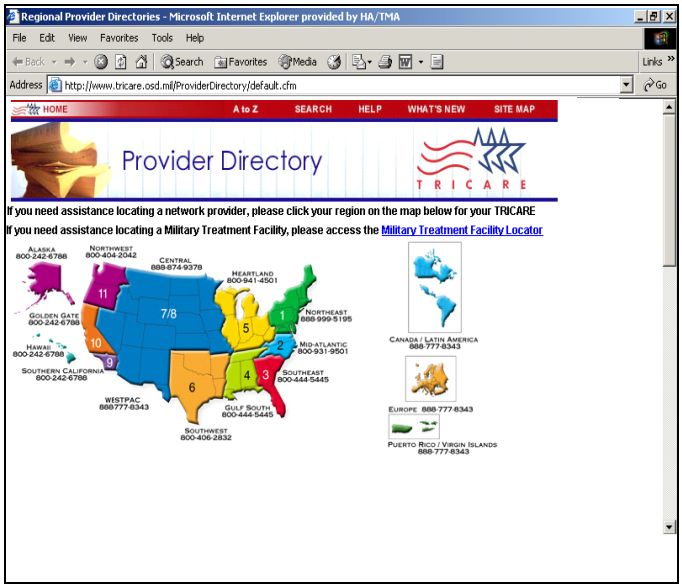
Participating Provider

A participating provider is a health care provider who participates in TRICARE, or accepts assignments, and agrees to accept the TRICARE allowable charge (including your cost share and deductible, if any) as the full fee for care. Individual providers can participate on a case-by-case basis. They file the claim and receive the check, if any, from TRICARE. Hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient care. For outpatient care, hospitals and providers have the choice of whether to participate.

Non-participating Provider

A non-participating provider is a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnishes medical services or supplies to a TRICARE beneficiary, and does not agree to participate or accept the TRICARE-determined allowable cost or charge as the total charge for the services. A non-participating provider looks to the beneficiary or sponsor for payment of his or her billed charge(s), not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor directly not the provider.

List of TRICARE authorized providers is available at
www.tricare.osd.mil/provider_directory.html.



Types of Charges in TRICARE

Allowable Charge

The allowable charge is the amount on which TRICARE Standard figures the beneficiary's cost share for covered care.

Balance Billing

Balance Billing is the provider billing a beneficiary for the rest of its charges after the beneficiary's civilian health insurance plan or TRICARE has paid everything it is going to pay. Federal law says the beneficiary is not legally responsible for amounts in excess of 15 percent above the TRICARE Allowable Charge.

Balance Billing Example

- Remember that a non-network provider can choose to participate or accept assignment on a case-by-case basis.
- A TRICARE Standard beneficiary sees a non-network provider for her cardiology appointment. The provider, who is a cardiologist, states that she will not participate or accept assignment for this appointment.
- The commercial rate for an outpatient cardiology appointment is $115.
  - TRICARE's allowable charge is $65.
  - The provider balance bills the patient for an additional 15% over the TRICARE allowable charge to recoup more money for the services she rendered.
    - Remember, 15% is the maximum allowable under federal law for a provider to charge above the TRICARE allowable charge.

To further illustrate:
$115 = commercial rate for the cardiology appointment
$65 = TRICARE allowable charge

The provider balance bills.
$65 = TRICARE allowable charge paid to the beneficiary by claims processing unit by check
x .15 = Percentage allowed by federal law
$9.75 = Billed by the provider to the beneficiary

Total amount due to the provider is $65 + $9.75 = $74.75

The beneficiary will receive a $65 check from the claims processing unit (WPS or PGBA) as the claim would have been filed by the beneficiary. The beneficiary must pay the provider for services rendered. The additional $9.75 is what the beneficiary pay out-of-pocket.

Note: Beneficiaries should wait for their EOB before paying the additional 15% to the provider.

Billed Charge

A billed charge is the total cost of care without discounts or reduced fees from a provider.

Co-pay

Co-pay is the term used in Prime, that specifies fixed amounts of out-of-pocket expense(s) borne by the beneficiary before the medical service or supply can be delivered.

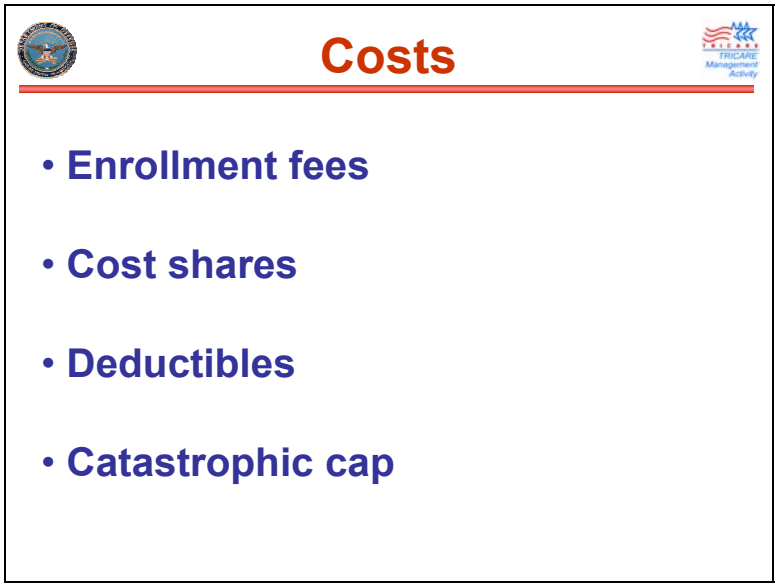
Cost Share

Cost Share is the out-of-pocket expense borne by the beneficiary for a medical service or supply based on the allowable charge under Standard or Extra. This is expressed as a percentage: 25% or 20%, respectively of the TRICARE allowable charge.

Health care options:

- TRICARE Standard
- TRICARE Extra
- TRICARE Prime

Costs



TRICARE Standard

- No enrollment fees or enrollment forms
- Freedom to choose any TRICARE-authorized provider, certified by the managed care support contractor, fee for service
- Beneficiaries may be required to file their own claims
- Available for all TRICARE-eligible beneficiaries, except active duty service members, dependent parents, and parents-in-law
- Beneficiaries can still receive their care from a military treatment facility (MTF) on a space-available basis.
- Beneficiaries can self-refer for specialty care.
- Beneficiaries are responsible for annual deductibles and cost shares.
- Government shares the cost with beneficiaries after deductibles are paid.
- For retired service members who have employer-sponsored health insurance, TRICARE Standard may be used as secondary coverage.
- Some outpatient procedures may require prior authorization.

Enrollment Fees	Cost Share after Deductibles
$0 Just show military ID	20% cost share for active duty families 25% for retirees and retiree families under age 65

The beneficiary must first pay the deductible per individual or family per fiscal year. The deductibles apply to outpatient care only.

	Annual Deductible for an Individual	**Annual Deductible for a Family**
Active duty family member of E-1 to E-4	$50	$100
Active duty family member of E-5 and up; and all others	$150	$300

Catastrophic Cap

The catastrophic cap is the maximum amount per fiscal year a beneficiary pays for TRICARE covered services or supplies.

	Active Duty Families Using TRICARE Standard	**Retirees/Retiree Family Members under Age 65**
Catastrophic cap	$1,000 per family per fiscal year (Oct. 1–Sep. 30)	$3,000 per family per fiscal year (Oct. 1–Sep. 30)

Payments counted toward a beneficiary's catastrophic cap include the following:

- Deductibles
- Cost shares, to include prescriptions

Payments that do not count toward a beneficiary's catastrophic cap include the following:

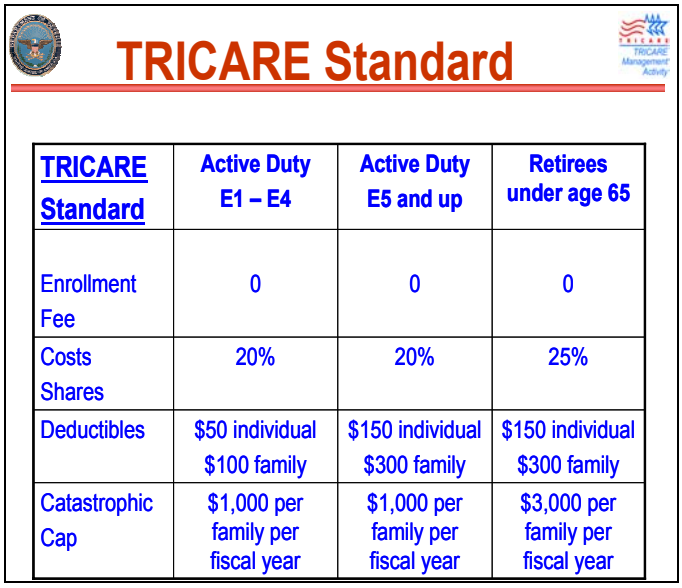
- Payments for balance billing (excess charges above the TRICARE allowable charge)
- Medicare premium payments

Inpatient Costs

	Active Duty Families Using TRICARE Standard	Retirees/Retiree Family Members under Age 65
Civilian inpatient cost share	Greater of $25 or $13.32* per day	Lesser of $459* per day or 25% of billed charges plus 25% of allowed separately billed professional fees
Civilian inpatient mental health	$20 per day	Lesser of $164* per day or 25% of allowable fees plus 25% of allowed separately billed professional fees

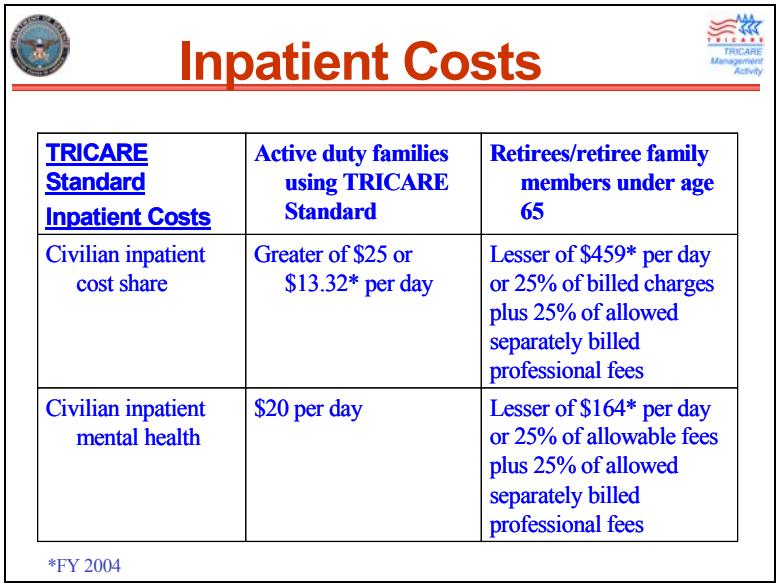
*Fiscal Year (FY) 2004 rates

Cost Comparison Matrix for Active Duty and Retirees



TRICARE Standard	Active Duty E1 – E4	Active Duty E5 and up	Retirees under age 65
Enrollment Fee	0	0	0
Costs Shares	20%	20%	25%
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

Inpatient Costs



TRICARE Extra

TRICARE Extra is the option where the beneficiary goes to a network provider and the cost share is 5 percent less than going to an authorized provider.

To get care with TRICARE Extra

1. Select civilian physicians and specialists from a list of providers on the managed care support contractor's network provider directory.
2. See network providers on a visit-by-visit basis. The provider will file the claim forms.

- Care only by TRICARE network providers
- Claim paperwork submitted by providers
- No enrollment fees or forms
- Available for all TRICARE-eligible beneficiaries, except active duty service members
- No primary care managers (PCMs)
- Beneficiaries are responsible for annual deductibles and cost shares.
- Government shares the cost with beneficiaries after deductibles are paid.
- No deductible when using retail pharmacy network

Enrollment Fees	Cost Share after Deductibles
$0 Just show military ID	15% cost share and copay for active duty families 20% for retirees and retiree families under age 65

The beneficiary must first pay the deductible per individual or family per fiscal year. The deductibles apply to outpatient care only.

	Annual Deductible for an Individual	Annual Deductible for a Family
Active duty family member of E-1 to E-4	$50	$100
Active duty family member of E-5 and up; and all others	$150	$300

Catastrophic Cap

The catastrophic cap is the maximum amount per enrollment year a beneficiary pays for TRICARE covered services or supplies.

	Active Duty Families Using TRICARE Extra	Retirees/Retiree Family Members under Age 65
Catastrophic cap	$1,000 per family per fiscal year (Oct. 1–Sep. 30)	$3,000 per family per fiscal year (Oct. 1–Sep. 30)

Payments counted toward a beneficiary's catastrophic cap include the following:
- Deductibles
- Cost shares, to include prescriptions

Payments that do not count toward a beneficiary's catastrophic cap include the following:
- Payments for balance billing (excess charges above the TRICARE allowable charge)
- Medicare premium payments

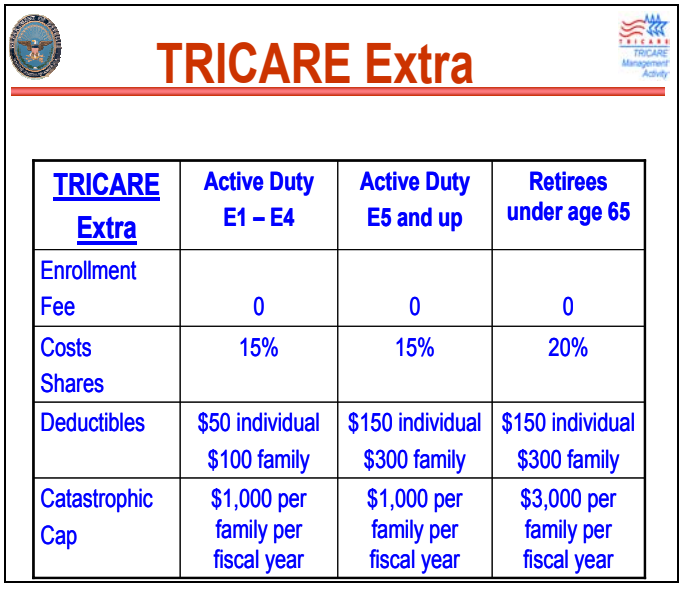
Note: As stated in contracts with the MCSCs, network providers cannot balance bill.

Inpatient Costs

	Active Duty Families Using TRICARE Extra	Retirees/Retiree Family Members under Age 65
Civilian inpatient cost share	Greater of $25 or $13.32* per day	Lesser of $250* per day or 25% of negotiated charges plus 20% of negotiated professional fees
Civilian inpatient mental health	$20 per day	20% of institutional and negotiated professional fees

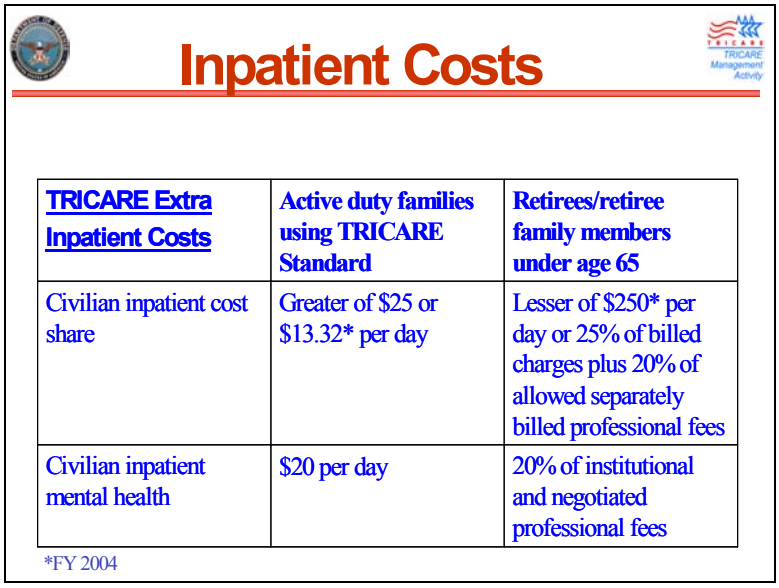
*FY 2004 rates

Cost Comparison Matrix for Active Duty Families and Retirees



TRICARE Extra	Active Duty E1 – E4	Active Duty E5 and up	Retirees under age 65
Enrollment Fee	0	0	0
Costs Shares	15%	15%	20%
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year

Inpatient Costs



TRICARE Prime

- No claims to file
- Requires enrollment to participate
- Assigned a PCM
- Managed care similar to a civilian health maintenance organization
- Active duty service members are required to enroll:
  - Active duty service members must complete an enrollment application; they are not automatically enrolled in TRICARE Prime on the Defense Enrollment Eligibility Reporting System (DEERS).
  - This is the only TRICARE option for which they are eligible.
  - Active duty service members receive priority care at all MTFs.
- Enrollees receive most of their care from military providers or from civilian providers who belong to the TRICARE Preferred Provider Network (PPN).
- TRICARE Prime is portable when you have a permanent change of station (PCS) or go on temporary duty/temporary additional duty (TDY/TAD).

Role of the PCM:
- Provides and coordinates care:
  - Provides all non-emergency health care including urgent care
  - Arranges for authorizations and referrals for specialty care
- Maintains health records
  - Active duty service members can get copies of their health records from civilian PCMs at no cost
  - All other Prime beneficiaries can get copies of their health records from civilian PCMs at a nominal cost

Preventive Care Services:
- Eye exams
- Immunizations
- Hearing tests
- Mammograms
- Pap tests
- Prostate exams

TRICARE Prime Enrollment:

- Open enrollment year round
- For TRICARE eligible beneficiaries, other than active duty service members:
  - 20th of each month is the cut-off date for all new enrollments for the following month
  - After the 20th, enrollment is effective the first of the second month
  - Enrollment is for a 12-month period
  - Reenrollment is automatic. Letter sent to sponsor 15 days before anniversary date of enrollment notifying of annual automatic reenrollment unless sponsor wants to disenroll.

Enrollment Process:

- To enroll in TRICARE Prime, eligible beneficiaries must be enrolled in DEERS and must complete an enrollment form (DD Form 2876) by visiting the local TSC or downloading the enrollment form from the TRICARE Web site (www.tricare.osd.mil/enrollment/). Beneficiaries should return the completed form along with the enrollment fee, if applicable by visiting the closest TSC or mailing it to the MCSC in the region where they live.
- Retirees and their family, Medal of Honor recipients and their family, former spouses, and others (not on active duty) so designated by DoD who are eligible beneficiaries pay an annual enrollment fee ($230.00 per individual/$460.00 per family) that must accompany the completed enrollment form. The fee is payable by: personal check, major credit card, travelers' check, money order, cashiers check, electronic funds transfer, or allotment. Payments can be made annually, quarterly ($57.50 individual/$115.00 family), or monthly ($19.17 individual/$38.34 family).

Note: Enrollment fees are waived for beneficiaries who are eligible for Medicare on the basis of disability or end-stage renal disease and maintain enrollment in Medicare Part B.

TRICARE Prime for Active Duty Service Members

- Required to use TRICARE Prime
  - Active Duty Service Members
  - National Guard
  - Reservists
  - ROTC Students – active duty when performing military-related functions
  - Service Academy Cadets – active duty when ID cards are issued on the first day at Service Academy

Active duty members and their families:

Enrollment Fees	Annual Deductibles	Copayments
$0	$0	$0

Active duty members receiving military inpatient care, pay only $8/day, if they are receiving subsistence pay. Otherwise they do not have to pay.

Enrollment fees for retirees and others, not active duty:

	Monthly	Quarterly	Yearly
Single	$19.17	$57.50	$230.00
Family	$38.34	$115.00	$460.00

Annual Deductibles	Copayments
$0	$12 outpatient $30 emergency care $25 mental health $17 mental health group session

- For electronic funds transfer and monthly allotment, the enrollment form should accompany the first quarter payment by a personal check, credit/debit card information, travelers' check, money order, or cashiers check.
- The beneficiary should call the regional contractor close to the end of the first quarter to see if the funds transfer or the monthly allotment is in effect.
  - Making this call will ensure continuity of care is not interrupted due to non-payment of monthly fees.

Note: Dual-eligible, is a beneficiary who has been designated Medicare eligible and does not pay the annual enrollment fee, so long as enrollment in Medicare Part B is maintained. A dual-eligible beneficiary must be registered in DEERS as having dual-eligibility.

Catastrophic Cap

The catastrophic cap is the maximum amount per enrollment year a beneficiary pays for TRICARE-covered services and supplies. This is less of an issue for active duty families using TRICARE Prime. It is more of a concern for retirees and their family members.

	Active Duty Families Using TRICARE Prime	**Retiree Families Using TRICARE Prime**
Catastrophic cap	$1,000 per family per fiscal year	$3,000 per family per fiscal or enrollment year

Payments counted toward a beneficiary's catastrophic cap include the following:
- Deductibles
- Cost shares

Payments that do not count toward a beneficiary's catastrophic cap include the following:
- Payments for balance billing
- Medicare premium payments
- Point of Service charges

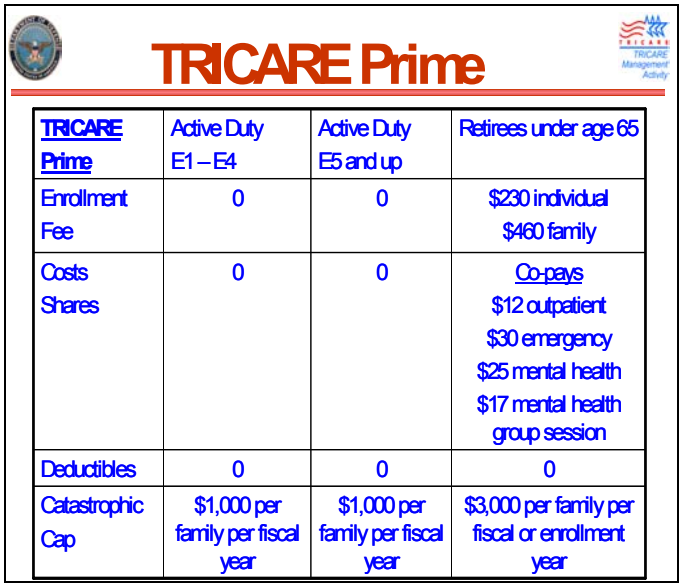
Note: As stated in contracts with MCSCs, network providers cannot balance bill.

Inpatient Costs

For retirees and their family members

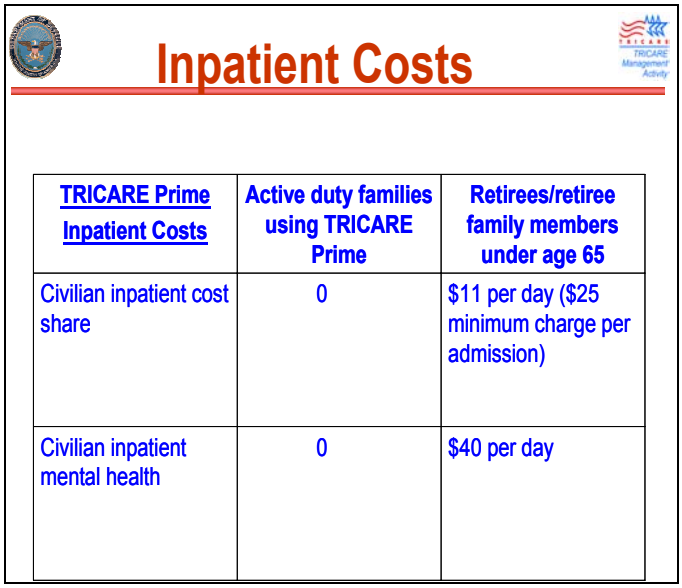
Civilian inpatient cost share	$11/day ($25 minimum charge per admission)
Civilian inpatient mental health	$40 per day

TRICARE Prime



TRICARE Prime	Active Duty E1 – E4	Active Duty E5 and up	Retirees under age 65
Enrollment Fee	0	0	$230 individual $460 family
Costs Shares	0	0	Co-pays $12 outpatient $30 emergency $25 mental health $17 mental health group session
Deductibles	0	0	0
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal or enrollment year

Inpatient Costs



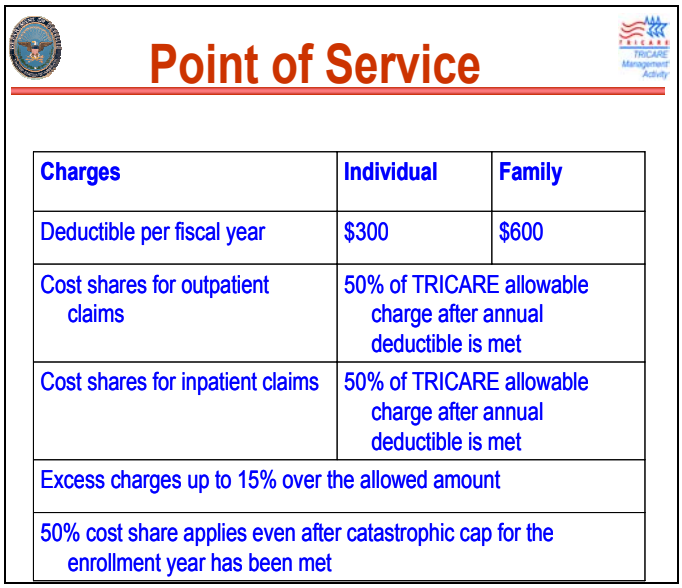
TRICARE Prime Inpatient Costs	Active duty families using TRICARE Prime	Retirees/retiree family members under age 65
Civilian inpatient cost share	0	$11 per day ($25 minimum charge per admission)
Civilian inpatient mental health	0	$40 per day

Point-of-Service Option (POS)

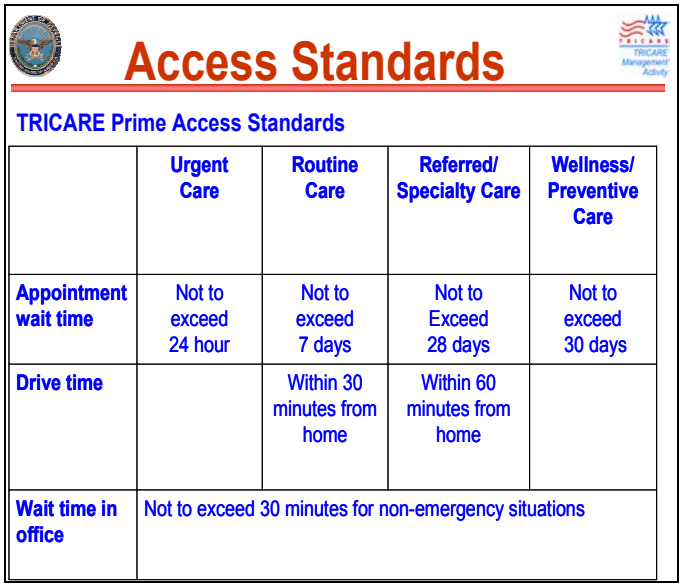
- Provides increased flexibility to see providers without authorization but at a significantly increased cost to the TRICARE Prime member.
- Enrollees can receive non-emergent health care services from any TRICARE-authorized civilian provider, in or out of network, without requesting a referral from the PCM or Health Care Finder (HCF).
- All TRICARE Standard options apply.

Charges	Individual	Family
Deductible per fiscal year	$300	$600
Cost shares for outpatient claims	50% of TRICARE-allowable charge after annual deductible is met	
Cost shares for inpatient claims	50% of TRICARE-allowable charge after annual deductible is met	
Excess charges up to 15% over the allowed amount		
50% cost share applies even after catastrophic cap for the enrollment year has been met		

Point of Service



Access Standards
This is the time it takes to see a provider based on the type of care being sought.



Access Standards

TRICARE Prime Access Standards

	Urgent Care	Routine Care	Referred/ Specialty Care	Wellness/ Preventive Care
Appointment wait time	Not to exceed 24 hour	Not to exceed 7 days	Not to Exceed 28 days	Not to exceed 30 days
Drive time		Within 30 minutes from home	Within 60 minutes from home	
Wait time in office	Not to exceed 30 minutes for non-emergency situations			

Emergency Services—Medical services provided for a sudden or unexpected medical or psychiatric condition or the sudden worsening of a chronic (ongoing) condition that is threatening to life, limb, or sight and needs immediate medical treatment, or which has painful symptoms that need immediate relief to stop suffering. In general, the patient goes to an emergency room or calls 911 (Prudent Lay Person Rule).

Urgent care—Generally defined as non-emergency illness or injury for which you need medically necessary treatment. But, it will not result in disability or death if it is not treated immediately. This kind of illness or injury does require professional attention, and should be treated within 24 hours to avoid further complications.

Routine Care—General outpatient (sick call) visits to a doctor, including laboratory tests and X- rays as well as preventive diagnosis health care.

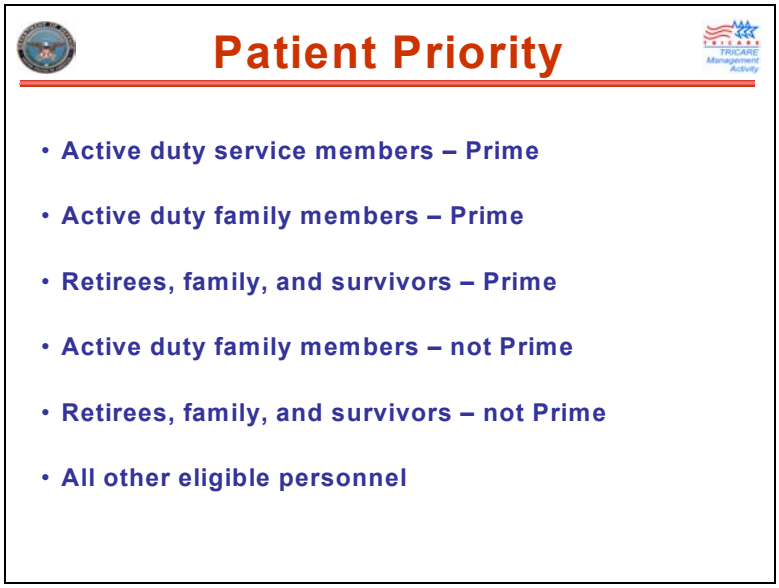
Specialty Care—Generally defined as care the PCM or provider is not able to provide.

Wellness/Preventive Care—Routine care with PCM based on history such as physicals.

Referral for Specialty Care

- When beneficiaries are referred for specialty care by their PCM, the PCM must write a referral or consult. It is the beneficiary's responsibility to make sure that the care is authorized by their MCSC for their region before they go to the specialty appointment. Getting the referral authorized can happen in at least two ways:
  - Beneficiaries take the written referral/consult from the PCM and obtain an authorization by calling their MCSC toll-free number and speaking to an HCF.
    - The HCF may make the appointment for the beneficiary.
    - Or the beneficiary may make the appointment.
  - The PCM sends the consult electronically to the MCSC, and, after waiting at least 48 hours so the consult can clear through the HCF, the beneficiary calls the MCSC toll-free number to make an appointment.
    - Some MCSCs will send letters to beneficiaries with the name of the provider and the authorization or referral.
    - The MCSC may include the date and time of the appointment or tell the beneficiary the provider's name so the beneficiary may contact the provider to make an appointment.
- The beneficiary should always take a copy of the consult, copies of all information pertaining to the referral (x-rays, labs, etc.), and the address and phone number of their PCM with them to their referral/specialty appointment.
- The beneficiary should be reminded that if they do not make sure there is a referral and authorization, they will end up paying out-of-pocket. The POS Option will be applied.
- As a BCAC, you need to find out what measures the local MTF has put in place to manage outpatient medical records and privacy standards by contacting:
  - Local patient administration division,
  - MTF privacy officer, or
  - MTF outpatient medical records office.

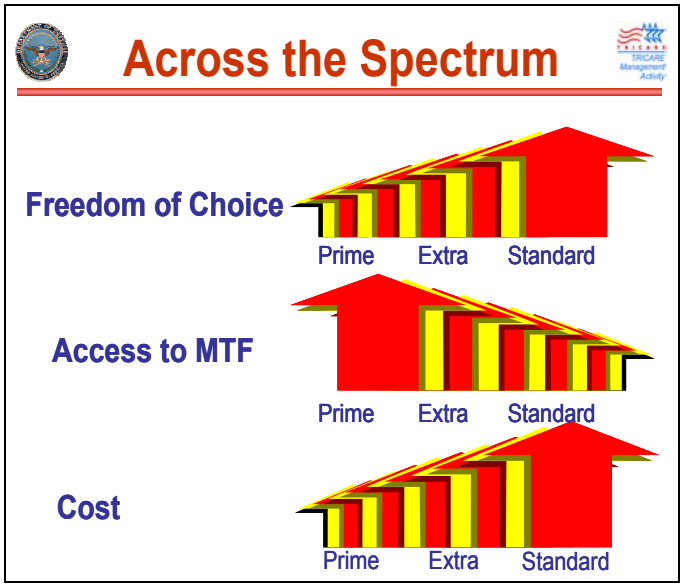
Patient Priority



The priority for care in an MTF is as follows:

1. Active duty service members
2. Active duty family members enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are enrolled in TRICARE Prime are included)
3. Retirees, their family members, and survivors enrolled in TRICARE Prime
4. Active duty family members not enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are not enrolled in TRICARE Prime are included)
5. Retirees, their family members, and survivors not enrolled in TRICARE Prime
6. All other eligible personnel

Across the Spectrum



TRICARE Portability

The TRICARE benefit is portable, meaning the benefit is the same no matter where a beneficiary lives or travels.

Within the Same Region

- Update address in DEERS.
- Notify MCSC of address change.
- Might need to change PCM.

To a Different Region

- Upon arrival at the new region, transfer enrollment to new MCSC.
- Select a new PCM.
- Complete transfer of enrollment within first month of arrival.
- Enrollment transfer is effective on the date new MCSC receives enrollment application.
- Both enrollment transfer and PCM selection can be done by visiting the TSC or contacting the MCSC. Beneficiaries will receive new enrollment cards and local health care information.
- Same enrollment period and anniversary date are retained.
- Future enrollment fees will be paid to the new MCSC.
- Active duty families may have unlimited number of enrollment transfers.

From TRICARE Prime to Non-Prime

- Covered in TRICARE Prime while in transit
- If anticipating a move to an area without TRICARE Prime, pay enrollment fees quarterly.
- Upon arrival at non-TRICARE Prime site, beneficiary should call the MCSC or visit the closest TSC regarding disenrollment.
- Beneficiary may sign a waiver to TRICARE Prime access standard to remain enrolled even when moving to a location that is out of the Prime service area or Catchment area.
  - Beneficiary will travel a longer distance to see a TRICARE Prime provider and must still abide by all the rules in TRICARE Prime.

Retirees and Their Eligible Family Members

- Retirees and their eligible family members who move from one region to another and then back to original region of enrollment are unofficially referred to as "snowbirds." TRICARE accommodates snowbirds but limits region-to-region moves to two per enrollment year.
- Number of moves within a region is unlimited.
- Can transfer enrollment to another region without paying additional enrollment fees.
- If anticipating a move to an area without TRICARE Prime, pay enrollment fees quarterly.
- If beneficiary will turn 65 during enrollment year, also recommend paying quarterly.

Maternity Care

- Active duty women who are pregnant do not have the option of participating in TRICARE Standard.
  - DoD policy dictates they must enroll in TRICARE Prime and receive OB/GYN care from an MTF.
  - They can only be seen by civilian providers and in civilian facilities if directed due to the lack of an MTF in the local area.
- Active duty pregnant women who voluntarily choose to administratively separate from the military should ensure they receive pre-separation counseling from their MTF in regards to available MTF resources to support their pregnancy and delivery upon separation.
  - They do not have TRICARE benefits.
  - They may enroll in the premium-based Continued Health Care Benefits Program (CHCBP) for 18 months.
  - A Certificate of Creditable Coverage will be issued by DEERS.

Traveling with TRICARE

- For emergency care, go to the nearest hospital emergency room based on the Prudent Lay Person Rule. No longer required to notify the Contractor or PCM within 24 hours. It is recommended that a copy of the treatment record be forwarded to the PCM. Immediate notification to the PCM and/or HCF is important in the TRICARE Overseas Program only.
- For non-emergency care including urgent care, beneficiaries should call for authorization from the PCM or HCF at the MCSC.

Split Enrollment Between Different TRICARE Regions

- Occurs when eligible family members live in a region different from their sponsor
- Pay one enrollment fee to whichever MCSC is chosen to be the home region by the beneficiaries in the region(s) where they live.
- Contact the MCSC or Beneficiary Counseling and Assistance Coordinator for more information.

Non-Availability Statement

- The non-availability statement (NAS) is a document issued by the MTF to a TRICARE Standard beneficiary that certifies a specific medical service is not available within the MTF at the time the care is needed.
  - As of December 28, 2003, MTFs will no longer issue a NAS to TRICARE Standard beneficiaries for non-emergency inpatient care.
  - This means beneficiaries no longer need prior authorization or documentation from the MTF.
  - Beneficiaries should check with the MCSC or TSC on certain categories of care that still require preauthorization.
- TRICARE Prime beneficiaries will still require referral and authorization from their PCM prior to seeing non-emergency civilian care.
- TRICARE Standard beneficiaries who seek mental health inpatient care will still require a NAS from their MTF.
  - This is one of the exceptions where a NAS is required in order for the TRICARE claim to be paid correctly.

Care at Department of Veterans Affairs (VA) Health Care Facilities

- Many VA health care facilities participate in regional TRICARE networks.
- VA facilities may or may not provide primary care for active duty service members and their family members.
- Many VA facilities provide specialty care.
- Contact the lead agent to find out if a participating VA facility can provide care or if a separate DoD VA agreement exists.

Choosing a Health Care Option

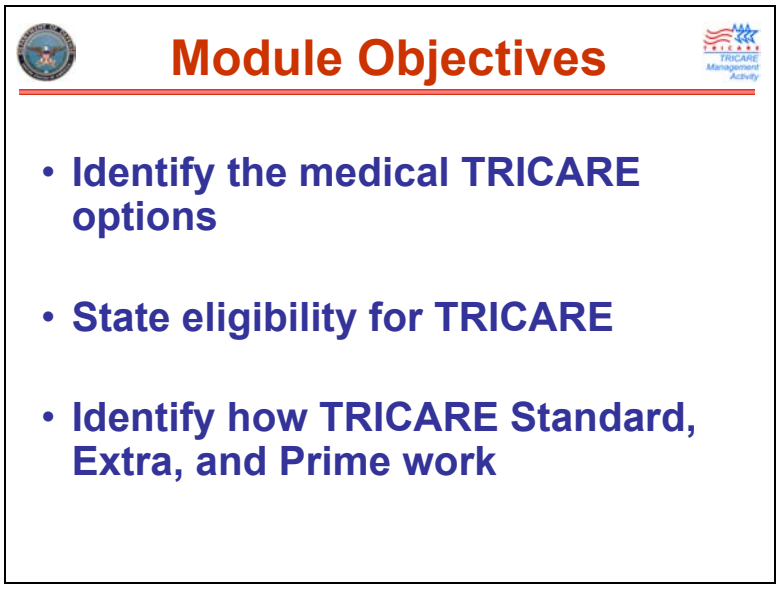
- Because choosing a health plan can be confusing and complex, a TRICARE Health Comparison Site was created.
  - Visit www.tricare.osd.mil/tricarecomparisions/admin/index.cfm
  - This site compares TRICARE Standard, TRICARE Extra, and TRICARE Prime to other health insurance.

Customer Service Commentary

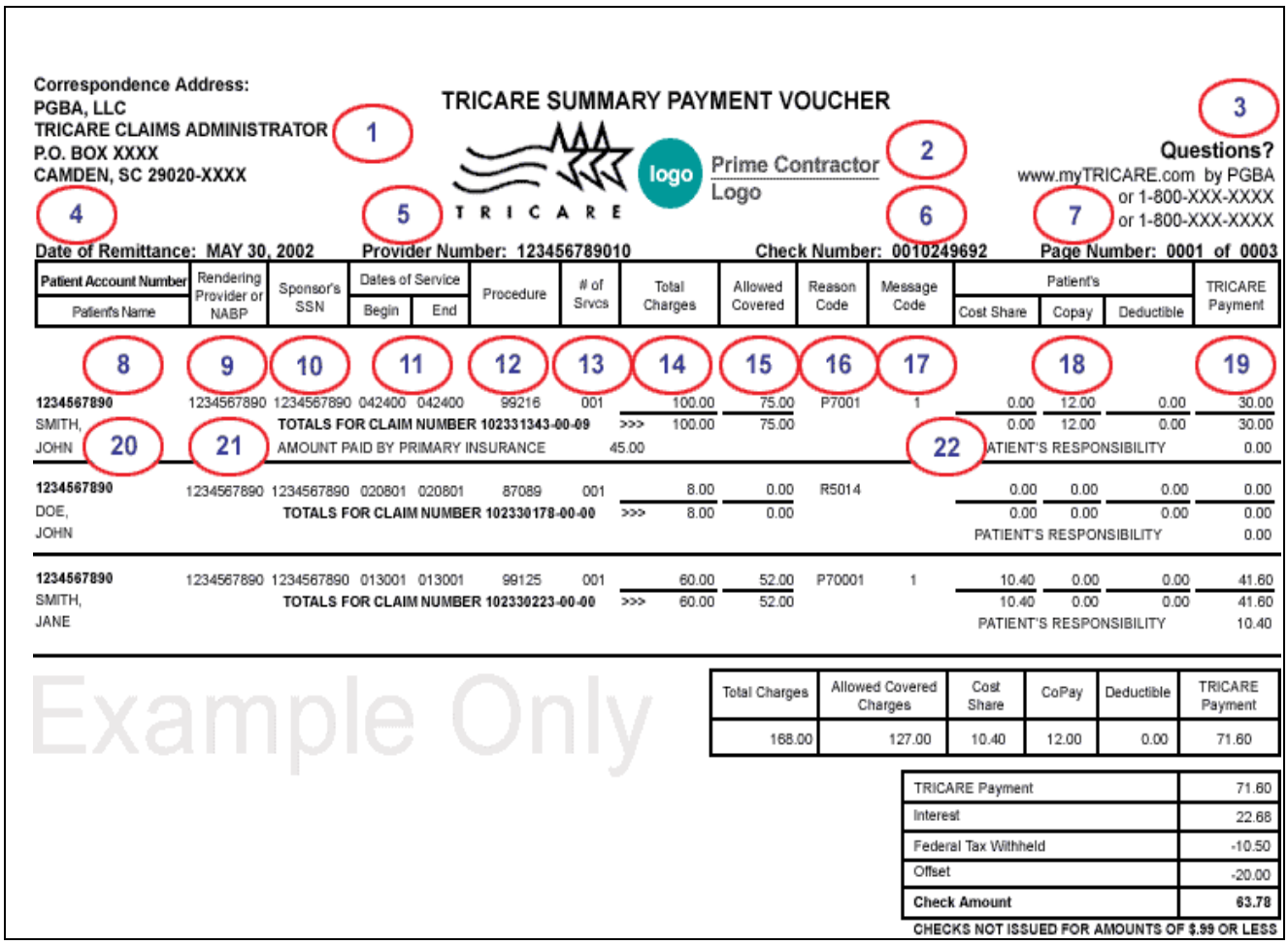
We all know the importance of first impressions. We never have a second chance to make a good first impression. Impressions can be easy to make and difficult to change. Let's focus on the last impression. We should strive to make the last impression as pleasant and positive as possible. Here are some comments to assist in making the connection with your customers.

- Is there anything else we can do for you today, SPC Jones?
- Thank you for the opportunity to serve you today Major Harrison. Please come again soon.
- It's always a pleasure to serve you Mrs. Brooks. We look forward to seeing you back in two weeks.

Summary



How to read PGBA's TRICARE Summary Payment Voucher
(Also known as an EOB or Explanation of Benefits)



Correspondence Address:
PGBA, LLC
TRICARE CLAIMS ADMINISTRATOR
P.O. BOX XXXX
CAMDEN, SC 29020-XXXX

TRICARE SUMMARY PAYMENT VOUCHER

TRICARE

logo Prime Contractor Logo

Questions?
www.myTRICARE.com by PGBA
or 1-800-XXX-XXXX
or 1-800-XXX-XXXX

Date of Remittance: MAY 30, 2002 Provider Number: 123456789010 Check Number: 0010249692 Page Number: 0001 of 0003

Patient Account Number / Patient's Name	Rendering Provider or NABP	Sponsor's SSN	Dates of Service Begin	Dates of Service End	Procedure	# of Srvcs	Total Charges	Allowed Covered	Reason Code	Message Code	Patient's Cost Share	Patient's Copay	Patient's Deductible	TRICARE Payment
1234567890	1234567890	1234567890	042400	042400	99216	001	100.00	75.00	P7001	1	0.00	12.00	0.00	30.00
SMITH, JOHN	TOTALS FOR CLAIM NUMBER 102331343-00-09						>>> 100.00	75.00			0.00	12.00	0.00	30.00
	AMOUNT PAID BY PRIMARY INSURANCE						45.00				PATIENT'S RESPONSIBILITY			0.00
1234567890	1234567890	1234567890	020801	020801	87089	001	8.00	0.00	R5014		0.00	0.00	0.00	0.00
DOE, JOHN	TOTALS FOR CLAIM NUMBER 102330178-00-00						>>> 8.00	0.00			0.00	0.00	0.00	0.00
											PATIENT'S RESPONSIBILITY			0.00
1234567890	1234567890	1234567890	013001	013001	99125	001	60.00	52.00	P70001	1	10.40	0.00	0.00	41.60
SMITH, JANE	TOTALS FOR CLAIM NUMBER 102330223-00-00						>>> 60.00	52.00			10.40	0.00	0.00	41.60
											PATIENT'S RESPONSIBILITY			10.40

Example Only

Total Charges	Allowed Covered Charges	Cost Share	CoPay	Deductible	TRICARE Payment
168.00	127.00	10.40	12.00	0.00	71.60

TRICARE Payment	71.60
Interest	22.68
Federal Tax Withheld	-10.50
Offset	-20.00
Check Amount	**63.78**

CHECKS NOT ISSUED FOR AMOUNTS OF $.99 OR LESS

1. Correspondence address for PGBA, LLC, your region's TRICARE Claims Administrator.
2. The name and logo of the Prime contractor, the health service and support contractor for your TRICARE region.
3. The toll-free phone number/Web address for PGBA, your TRICARE Claims Administrator.
4. The date PGBA prepared this TRICARE payment voucher.
5. Social Security Number (SSN) or TIN of the provider who performed the services.
6. Number of the check issued as payment for the claim(s).
7. Number of this page followed by the total number of pages.
8. The patient's account number assigned by the provider's office and the patient's name.

9. SSN or TIN of the provider who performed the services or the provider's National Association of Boards of Pharmacy number.
10. The SSN of the military service member (active duty, retired or deceased).
11. Beginning and ending dates the services were performed.
12. CPT4 procedure code(s) or HCPCS equipment code(s) that identify the service(s) the provider performed.
13. The number of services the provider performed.
14. Total amount the provider billed for the services.
15. Amount TRICARE approves for the services.
16. This code corresponds to an explanation on the last page of how this claim was paid.
17. This code corresponds to a message on the last page that explains more about your claims payment.
18. Amounts subtracted from the total payment that are the patient's responsibility to pay.
19. Amount TRICARE has paid for the billed services.
20. If the claim was paid as DRG, the Diagnosis Related Group number would appear.
21. Total amounts for the claim and the amount other health insurance paid.
22. The amount the patient must pay the provider, including cost-shares, copayments, deductibles and non-covered charges.

Bottom of Form

TRICARE4U

TRICARE Northwest
P.O. BOX 7973
MADISON, WI 53707-7973

TRICARE SUMMARY
PAYMENT VOUCHER
B399161787 V

TRICARE EXPLANATION OF BENEFITS

Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice of your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-404-0110
Providers: 1-800-404-3117

COLONEL MUSTARD
309 CLUE LANE
SEATTLE WA 98063

WELBY, MARCUS MD
07/08/03

All Communications regarding these claims must reference the claim number.

	THIS IS NOT A BILL	

SPONSOR NO 399161787
PATIENT ACC # 55555555
SPONSOR COLONEL MUSTARD

PATIENT NAME
COLONEL MUSTARD

CLAIM NO
2003189 53 49996

PROVIDER	SERVICE DATES	PROC	MOD	NO	TYP	BILLED	ALLOWED	CODE
WELBY, MARCUS MD	02/01/03-02/01/03	81000		01	05	55.00	4.43	003
					TOTAL	55.00	4.43	

OTHER INS. ALLOWED	OTHER INS. PAID	REDUCTION DAYS	REDUCTION AMOUNT	PAID BY PATIENT
0.00	0.00	0	0.00	0.00

	DEDUCT	COST-SHARE/ COPAYMENT	TOTAL PAYABLE	INTEREST PAID	NET PAYMENT
**	0.00	0.00	4.43	0.00	4.43

REMARKS

PAYMENT HAS BEEN MADE TO THE PROVIDER OF CARE.
$1,146.53 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $3,000.00 FOR THE FISCAL YEAR '03.
TOTAL BENEFICIARY LIABILITY IS $5.09.
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '03 IS $139.13.
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '03 IS $139.13.

CODE 003

IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION, YOU HAVE THE RIGHT TO REQUEST A
REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE. SEE ITEM FIVE ON REVERSE OF PAGE 1.

**********VOUCHER SUMMARY**********

TOTAL PAYMENT	NET PAYMENT
4.43	4.43

TRICARE4U Eob Back Text

IMPORTANT NOTICE

1) THIS NOTICE CAN BE USED:

A. As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.
B. As a record of bills paid or denied (if you submitted other medical expenses not show on this form, you will receive a separate notice.)
C. To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

IF YOU NEED MORE INFORMATION:

- Check your TRICARE handbook.
- See the Health Benefits Advisor or Health Care Finder at the nearest Uniformed Services medical facility.
- Always give your Sponsor's Social Security number when writing about your claim.
- If inquiring about this claim, please provide the claim number located on the front of this form.
- Contact us at the telephone number shown on the front of this form.
- Written inquiries except Appeals (see #4) and Grievances (see #10) should be mailed to the following address:

  Foundation Health Federal Services
  TRICARE Services, Correspondence Unit
  P.O. Box 7973
  Madison, WI 53707-7973

2) TIME LIMIT FOR FILING CLAIMS:

For services received:	File Claims By:
1 Jan 93-31 Dec 93	31 Dec 94
1 Jan 94 & after	1 year after Date of Service

All claims for benefits submitted under TRICARE for dates of service prior to January 1, 1994 must be filed with the appropriate TRICARE contractor no later than December 31 of the calendar year immediately following the year in which the service or supply was provided. For services on and after January 1, 1994, all claims must be filed with the appropriate TRICARE contractor no later than one year from the date of service or, the date of discharge in the case of inpatient care.

If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your Health Benefits Advisor for assistance. In limited circumstances, exceptions may be made.

5) IF PAYMENT NOT BASED ON THE FULL AMOUNT BILLED:

The amount TRICARE may pay is limited by law to the **lowest** of:

A. The TRICARE Maximum Allowable Charge: i.e. the charge made 80 percent of the time by physicians or suppliers in the country for similar services during the base year adjusted by where the services were rendered; or
B. Prevailing charge; i.e. the charge made 80 percent of the time by physicians or suppliers in the state for similar services during the base year; or
C. The amount the provider actually charges for the service or supply; or
D. The fiscal year 1988 prevailing charge adjusted by the Medicare Economic Index (MEI); or
E. The discounted charge that a provider has agreed to accept under a special program approved by the Directory, TRICARE.

6) PATIENT'S SHARE OF THE COST FOR AUTHORIZED CARE:

Inpatient Benefits *See remarks on front.

Outpatient Benefits:	
Active duty family members of sponsor E-4 and below:	First $50 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $100 per family plus 20% of allowable charges after deductible has been paid.
Active duty family members of sponsor E-5 and above:	First $150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $300 per family plus 20% of allowable charges after deductible has been paid.
Former spouses, non-active duty members and their families:	First $150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $300 per family plus 25% of allowable charges after deductible has been paid.

Claim payments are subject to the provision that the beneficiary cost-share is collected by the provider. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

7) SPONSOR, PATIENT, OR DEPENDENT NOT ENROLLED OR NOT ELIGIBLE ON DEERS:

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or

3) TYPE OF SERVICE CODES:

First Position:

A = Ambulatory surgery cost-shared as inpatient (Active Duty family members only)
I = Inpatient
M = Outpatient maternity care cost-shared as inpatient
N = Outpatient cost-shared as inpatient
O = Outpatient Care Other
P = Outpatient partial psychiatric hospitalization care cost-shared as inpatient

Second Position:

1 = Medical Care
2 = Surgery
3 = Consultation
4 = Diagnostic/Therapeutic X-Ray
5 = Diagnostic Laboratory
6 = Radiation Therapy
7 = Anesthesia
8 = Assistance at Surgery
9 = Other Medical Service
A = DME Rental/Purchase
B = Drugs
C = Ambulatory Surgery
D = Hospice
E = Second Opinion on Elective Surgery
F = Maternity
G = Dental
H = Mental Health Care
I = Ambulance
J = Program for Persons with Disabilities

4) YOUR RIGHT TO APPEAL THIS INITIAL DETERMINATION:

If you disagree with the determination on your claim, you have the right to request reconsideration. Your **SIGNED** written request must state the specific matter with which you disagree and **MUST** be mailed to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

TRICARE Appeals
ATTN: APPEALS
P.O. Box 8370
Madison, WI 53708-8370

Should a beneficiary unknowingly receive services for non-TRICARE benefits, the beneficiary will not be held responsible for the charges.

dependent is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Future claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card or (parent's ID for dependent children under 10 years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's (ID) card. If the sponsor is deceased, report to any service personnel office to get enrolled or call the appropriate number listed below.

8) IDENTIFICATION CARD (ID) OR ELIGIBILITY EXPIRED ON DEERS:

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to any parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card (both front and back sides). In an emergency, call the appropriate number listed below.

FOR DEERS INFORMATION CALL:
CALIFORNIA……1-800-334-4162
HAWAII & Alaska 1-800-527-5602
ALL OTHER STATES 1-800-538-9552

9) BENEFICIARY NOTICE:

Please review the services shown on the front side of this TRICARE Explanation of Benefits. If you find that payment consideration has been made for any services that you did not receive; or that services were provided by a health care professional that you did not see, please call the FRAUD AND ABUSE number at 1-800-977-6761.

10) TO FILE A GRIEVANCE:

If you become dissatisfied with the quality, timeliness or accessibility of care, you may file a grievance. Mail your written grievance to:

FHFS – QM Department
Attn: Grievances
3600 Port of Tacoma Road, Suite 505
Tacoma, WA 98424

TRICARE4U

TRICARE Northwest
P.O. BOX 7973
MADISON, WI 53707-7973

TRICARE SUMMARY
PAYMENT VOUCHER
P910567267989020000 V

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Administered by: Health Net Federal Services, Inc.

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Beneficiaries: 1-800-404-0110
Providers: 1-800-404-3117

HOLY SMOKES HOSPITAL
2811 TIETON DRIVE
YAKIMA WA 98902-3761

HOLY SMOKES HOSPITAL
05/01/03

All Communications regarding these claims must reference the claim number.

THIS IS NOT A BILL

PATIENT ACC # 43039049309

PATIENT NAME	SPONSOR NO	CLAIM NO
PAUL BUNYAN	001122334	2003121 53 49992

SPONSOR NAME PAUL BUNYAN

PROVIDER	SERVICE DATES	DESCRIPTION	BILLED	ALLOWED	CODE
HOLY SMOKES HOSPIT	04/01/03-04/02/03	AUTHORIZE PRIV RM	300.00	0.00	236

DRG	DX1	DX2	DX3	DX4	PRC1	PRC2	PRC3	DSCH ST	YOB	SEX	OUTLIER
	DX5	DX6	DX7	PRC4	PRC5	PRC6					
	DX8	DX9									
000	56213							01	45	M	NONE

	PAID BY PATIENT	OTHER INS. PAID
**	0.00	100.00

	BILLED	COST-SHARE/ COPAYMENT	INTEREST PAID	NET PAYMENT
**	300.00	0.00	0.00	0.00

REMARKS

$1,394.27 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $3,000.00 FOR THE FISCAL YEAR '03.

CODE 236

OUR RECORDS INDICATE THAT YOU HAVE TWO OR MORE HEALTH INSURANCES THAT ARE PRIMARY TO TRICARE. YOUR CLAIM WAS DENIED BECAUSE WE DID NOT RECEIVE EXPLANATIONS OF BENEFITS (EOBS) FROM ALL OF YOUR INSURANCES FOR THE CHARGES SUBMITTED TO TRICARE.

**********VOUCHER SUMMARY**********

TOTAL PAYMENT	NET PAYMENT
0.0	0.00

TRICARE4U Eob Back Text

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Attn: Grievances
3600 Port of Tacoma Road, Suite 505
Tacoma, WA 98424